Meeting Minutes
Health Information Technology Council Meeting

August 5, 2013
3:30 – 5:00 P.M.

One Ashburton Place, 21th floor Matta Conference Room
Boston, MA

Meeting Attendees

Name	Organization	Attended
John Polanowicz	*(Chair) Secretary of the Executive Office of Health and Human Services*	No
Manu Tandon	*(Chair) Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	Yes
John Letchford	*Chief Information Officer, Commonwealth of Massachusetts*	*
David Seltz	*Executive Director of Health Policy Commission*	*
Aron Boros	*Executive Director of Massachusetts Center for Health Information and Analysis*	No
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Yes
Eric Nakajima	*Assistant Secretary for Innovation Policy in Housing and Economic Development*	No
Patricia Hopkins MD	*Representative from a small Physician group Practice Rheumatology & Internal Medicine Doctor (Private Practice)*	Yes
Meg Aranow	*Senior Research Director, The Advisory Board Company*	No
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Yes
John Halamka, MD	*Chief Information officer, Beth Israel Deaconess Medical Center*	Yes
Normand Deschene	President and Chief Executive Officer , Lowell General Hospital	No
Jay Breines	Community Health Center	Yes
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	Yes
Michael Lee, MD	*Director of clinical Informatics, Atrius Health*	No
Margie Sipe, RN	*Nursing Performance Improvement Innovator, Lahey Clinic*	Yes
Steven Fox	*Vice President, Network Management and Communications, Blue Cross Blue Shield MA*	No
Larry Garber, MD	*Medical Director of Informatics, Reliant Medical Group*	No
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Yes
Kristin Madison	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve college of Health Sciences*	Yes
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	Yes

Guest

Name	Organization
Nick Welch	EOHHS
Kim Grose	EOHHS
Rob McDevitt	EOHHS
Sean Kennedy	MeHI
Micky Tripathi	MAeHC

Carol Jeffery	MAeHC
Jennifer Monahan	MAeHC
Mark Belanger	MAeHC
Brian Sandager	Lowell General Hospital
Andrew Gilboard	LGH
Heather Nelson	Bay State Health
Lisa Fenichel	E-Health consumer Advocate
Kathleen Snyder	EOHHS
Ryan Mansfield	Tufts MC
Sarah Moore	Tufts MC
David Bacharn	NEQCA
David Whitham	EOHHS
David Bryant	MTC
David Manauso	MCS
Rita Cramer	Lahey Health System
Alec Ziss	Consumer Group, Cape Care
Kathleen Donaher	Regis College
Kimberly Haddad	A& F
*Iyern Romm	In Place of David Seltz
*Claudia Boldman	In place of John Letchford

Meeting Minutes:

Meeting called to order – minutes approved

The meeting was called to order by Manu Tandon 3:38 pm.

The Council reviewed minutes of the July 1st, 2013 HIT Council meeting. It was noted that Needham was misspelled. The minutes were approved with the spelling correction.

Discussion Item 1: Last Mile Program Update (Slides 4-18)

See slides 4-18 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Last Mile Program Update- Presented by Massachusetts eHealth Institute (MeHI) Health Information Exchange Director Sean Kennedy.

Sean Kennedy provided the Council with three handouts; "MA HIway Overview"," Use Case Development Guide" and "HIway Interface Grants."

(Slide 4) Agenda – The Council reviewed the agenda topics to be presented.

(Slides 5-6) Outreach- The Council was updated on the Last Mile program's current outreach efforts, focusing on building awareness in the community.

(Slide 7) HIway Interface Grants- The goals of the HIway interface grants focus on vendor development of Direct-compliant interfaces that can be built into the electronic health record (EHR) workflow and will accelerate connections to the HIway.

(Slide 8) Grant Requirements- Grantees must adhere to Direct standards, have 4 or more current installations of the product and version, and make the interface available to all customers by 1/31/2014.

(Slide 9)The Interface Grant Milestones- Grantees are tracked through a logical set of 4 project milestones from conceptualizing the architecture, to having a test transaction exchanged.

(Slide 10) Grantee Description- 9 out of 12 vendors have signed the grant agreement. The Council was provided with a list of contractors and a description of the contract amount. Collectively there are 15 vendors interested in doing work with the HIway.

(Slides 11) HIway Implementation Grants- The Implementation Grants will further build awareness of the HIway. For grantees, each had to pitch a measure to track, providing a use case story to help accelerate connections to the HIway. In the spring of next year there will be tangible stories to share to help further demonstrate the HIway's value.

- Question (Kathleen Donaher): Could you briefly describe how behavioral health PHRs are defined and how the patient engagement is defined?
    - Answer (Sean Kennedy): Behavioral Health providers like eHana have their EHR workflows specifically tuned to Behavioral Health.
- Follow up Question (Kathleen Donaher): How do they define community? For example you may define the community as individuals with an ICD-10 code. How do you define it?
    - Answer (Sean Kennedy): I don't know the specifics behind the ICD-9 code – The behavioral health tend to be more in the ambulatory practices, less on the inpatient side – so I suspect its largely their population and the case mix they receive in their population. Most organizations are going to define themselves as behavioral health practice fairly clearly.
- Follow up question (Kathleen Donaher): I'm thinking behavioral health, healthy behaviors… and then patient engagement how is that described?
    - Answer (Sean Kennedy): So these are organizations that are working with a provider and a patient community to create a conduit for communication. Sean then described an example of how NexJ systems works to facilitate sharing of a care plan between a patient and provider.

(Slide 12) Grant Agreement Update- To date, 31 of 32 Grant Agreements (waiting on Life Image) have been signed and 4 of 31 grantees have achieved the first milestone. Grantees include behavioral health facilities, long-term care facilities, and small practices. Out of this pool of grantees we estimate around 75 Mass HIway Participant Agreements (PA).

- Question (Kathleen Donaher): What is PA?
    - Answer (Sean Kennedy): Participation Agreement.

(Slide 13) Grantees and Their Trading Partners by Location- The Council was presented with a map of the 32 grantees and their 80 unique trading partners.

(Slide 14) Implementation Grant Milestones- Grantees will be tracked using four milestones: Participant Agreements signed, Initial Participant Directory loaded, Successful Test Transactions and Production Transactions. The milestones must be complete before January 21st 2014.

(Slide 15) PO's and Grantees- The Project Officers and a list of their designated Grantees were provided. Kevin Mullen and Jim Bush (MAeHC) are taking on the lion's share of the grantees. Joe Kynoch is managing all of the interface grantees. Keely Benson oversees the Massachusetts Department of Public Health Network (MDPHnet) grant and Sean Kennedy oversees Baystate Health and the Berkshire Health System.

(Slide 16) Last Mile Scorecard Targets- The Scorecard provides an estimate of PA's signed versus the actual number of PA's signed. MeHI plans to engage 2 new Customer Relationship Management (CRM) resources as well as the REC program to help ramp up the recruitment program. The Scorecard tracks the number of organizations enabled for a connection, the number of vendors enabled for connection, and the amount of The Office of the National Coordinator for Health IT (ONC) grant monies spent.

- Question (Lisa Fenichel): Can you explain exactly what that means (referring to the ONC Grant $ Spent row on slide 16)?
    - Answer (Sean Kennedy): This is the ONC money we have received for the statewide HIE program. We got ~$13.9 million and that includes the HIway dollars as well as the challenge grants – Improving Massachusetts Post-Acute Care Transfers (IMPACT) and Massachusetts Department of Public Health Network (MDPHnet). Take out the challenge grants and focus on the HIway and the Last Mile and you are looking at percent spent of that (the HIE/Last Mile grant monies awarded); at the end of in Q1, in March, we were at 35% spent of those dollars; 44% at the end of Q2, which is roughly reflected here (referring to the "thermometer graph on slide 16); so $5.9 million was spent.
- Follow-up Question (Lisa Fenichel): Is there pressure to spend the money?
    - Answer (Sean Kennedy): There is a pressure and an interest. Fortunately most states are in the same bucket, there is usually a fair amount of money left over at the end of the year. Many parts of the program are backed into the end of the program, which will result in an increase in ONC grant monies spent.
- Follow-up Question (Lisa Fenichel): Why is the total at 91%?
    - Answer (Sean Kennedy): There are additional programs I will walk us through later, including a Program Evaluation. The slide represents dollars spent, not dollars committed.
    - Answer (Lawrence Stuntz): ONC has not announced if they will allow grant no-cost extensions for the statewide HIE programs. ONC has said that they will not be providing no-cost extensions for the Regional Extension Center program.

- Follow-up Question (Lisa Fenichel): Do you mean that they can retain monies not spent for us in another quarter without needing to refund the monies?
    - Answer (Lawrence Stuntz): We do not need to refund because we only receive the money when we spend it and draw funds down. A no-cost extension would allow us to draw down funds beyond the current grant end date.

(Slide 17) Coming Soon- The Last Mile team is now looking at a Community Engagement program which can not only inform patients and providers, but also ease the ability to consent patients down the road and make it easier for providers and practice administrators to engage patients at the front desk. MeHI will provide more detail and updates next month. The Provider Toolkit will be a conduit for providers to spread information providing basic information. The HIway Services Summary "whitepaper" provides organizations with basic information they can share with their community. The Implementation Grant Summary will be a summary of each grant for healthcare professionals and use with media outlets. We'd like to bring in one of the grantees to speak to the HIT Council meeting next month.

- Comment (Alec Ziss): One of my concerns as a former practice administrator is putting the emphasis on providers. They are so busy taking care of patients and following up with insurance issues for example, the amount of time they will be able to spend with their patients to explain these issues is limited. There should be a way to effectively work with providers to address their needs, and take some of the burden off from them.

Discussion Item 2: Mass HIway Implementation Updates (Slides 19-39)

See slides 30-39 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides

Baystate Health and the Pioneer Valley Information Exchange (PVIX) - Presented by Senior Director Enterprise Clinical Applications and IT operations, Heather Nelson.

(Slide 20) Agenda- The Council reviewed the agenda topics to be presented.

(Slide 21) Fast Facts about Baystate Health- The Council was provided with background information about Baystate Health. Currently Baystate employs over 10k full time employees (FTE's) spread across four facilities. Outpatient facilities include home care and hospice, primary and specialty care and academic provider practices.

(Slide 22) Awards- Baystate has won a number of awards (see slide for full list). Significant awards in 2013 include an award from The Leapfrog Group for all four hospitals and the "Most Wired Hospital" for the 2nd year in a row. PVIX aims to be the main "hub" for Western MA, recognizing that patients see providers all over Pioneer Valley and providers will need access to those patients information.

(Slide23) Connecting our Communities of Care- Baystate aims to provide clinicians with easy access to patient records, empower patients to play a more active role in their treatment and to collaborate and connect with the community for a more unified vision of the HIE.

(Slide 24) PVIX as the Connector- PVIX recognizes that there are a large number of HIEs in Western MA and wants to make sure that trading partners are not having to connect to 15 different HIE's. Holyoke and Mercy have HIEs located right up the street from PVIX. The organization is working to make sure everyone in the community comes to the table by holding stakeholder meetings, including a Summit earlier this spring.

(Slide 25) Initiated by the Community- From the start, PVIX sought to engage all community players and trading partners representing large and small groups. PVIX wanted help with the design, and to understand the needs and concerns of its providers. Baystate includes Health New England which is their Health Maintenance Organization (HMO), and insurance information will be included in the exchange. Baystate also has a Physician Hospital Organization (PHO) which is the managed services organization for PVIX, helping to further enforce that Baystate wants to make this more about patients and providers in the community, not just Baystate Health. Vendor selection was conducted through a multi-stakeholder process.

- Question (Kathleen Donaher): Go-live requires much testing, but when we go live to 6.6 million MA residents, what will that interface look like? If I am Heather Nelson the patient, when will we go live with my interface?
    - Answer (Heather Nelson): Right now we are just talking about Baystate Health patients, not on-boarding the entire MA patient population. Baystate owns its patient data and lots of testing and validation will happen before any information is shared. As a patient at Baystate, your data is available to your care team only. As other partners join, their patients will join, and there is a consent process they will go through. Baystate is working to layer on a patient engagement platform to allow patients to interact with clinicians and pull their own health data. In the October timeframe a few practices will pilot the platform. We do not have Behavioral Health representation at this time, but it is in the works.

(Slide 26) PVIX is the Foundation to a Larger Information Platform Vision- PVIX recognizes that there are opportunities to better leverage the HIE. With programs like Meaningful Use the emphasis was getting the data in, now we need to get the data out; recognizing that there are multiple data sources, and data feeds from Baystate and the trading partners. Aggregated data repositories are going to help create the knowledge platform. Organizations will need to have data liquidity to make good decisions; from both a clinical and business prospective. The Innovation Center was recently awarded 5.5 Million dollars from the Research Center to help with analytics and tools that can be used across Pioneer Valley.

(Slide 27) PVIX and MeHI Grant Timelines- The Council was provided a timeline of where PVIX is in it's HIE deployment process (see slide for details). One of the biggest milestone challenges was getting the Participation Agreements vetted from the lawyers.

- Question (Kathleen Donaher): What will "go-live mean?"
    - Answer (Heather Nelson: All of the Baystate data for Baystate health (From Cerner EHR) will be loaded with 18 months worth of data for access on PVIX. Baystate

Visiting Nurse Association (VNA) and Hospice are on Cerner, but not integrated with Cerner Millennium. This requires use of a single sign on so that those providers can access PVIX.

(Slide 28) Phase 1- Connecting Our Communities-Key features and functions for Phase 1 were provided: MPI, demographics and visit information, including lab results and encounter event notifications.

(Slide 29) PVIX Architecture- The Council was provided with a high level look at the PVIX Architecture. Analytics will not be part of Phase 1 because there will not be enough trading partners to make it valuable at this point. If a partner does not have an EHR there will be a Provider Portal that they can use.

(Slide 30) Patient Consent- Exchanges today are still based on Health Insurance Portability and Accountability Act Treatment, Payment and Operations (HIPAA TPO). PVIX participant Notices of Privacy Practices (NPP) are required to name PVIX and the Mass HIway. PVIX is providing templates that will help participants adhere to state and federal regulations. PVIX has data access controls - Clinicians cannot go fishing for information, they must confirm their identity, and all activity is auditable.

- **Question (**Daniel Mumbauer): If you are "opt out," can trading partners be "opt in?"
    - Answer (Heather Nelson): Yes, we are giving them the opportunity to do so. PVIX is helping with the language for those that choose opt in. Baystate does not want to make this onerous; what if a doctor has 500,000 patients, does he or she need to get the consent from every single patient, even if they have not seen them in years? Updating the NPP with the information, which needs to be updated anyways (per HIPAA Omnibus), is one solution. Trading partners can choose which they would like to do, but at bear minimum need to meet the PVIX objectives.

(Slide 31) PVIX-HIPAA-Based Controls- Example policy and technology controls were provided to the Council.

- Question (Kathleen Donaher): PVIX is opt out, but the state is opt in? How will that work?
    - Short discussion among John Halamka, Heather Nelson, and Micky Tripathi clarified that the opt in language in Chapter 305 applies to statewide HIEs and that PVIX is a private not a statewide HIE.
- Follow up Question (Kathleen Donaher): In terms of performance metrics, there is research around what you are talking about is associated with a higher number of transactions, hence success. I am concerned about where the rubber hits the road. Looking at some of the use cases, which are linked to an outcome, but I am not seeing any real targets. We might consider ourselves successful if we design success around the number of transactions.
    - Answer (Heather Nelson): We have never done this before, and we want to do this because it is the right thing to do for patient care and our providers that see patients all over.

(Slide 32) Updates on MeHI Grant- There are four aims PVIX is focusing on: transition of care alerts, collaboration and information exchange, care plan dissemination and medication adherence. Baystate is

specifically focused on heart patients for this grant. The preliminary architecture design is underway with internal and external resources. The project plan was submitted to MeHI and the PA was returned, completing Milestone 1.

(Slide 33) PVIX to MA HIway Architecture- The Council was provided with a diagram of how it will look when PVIX connects to the HIway.

(Slide 34) PVIX Relationship with HIway-The "chain of trust extension," will require PVIX members to sign the PVIX PA which will also include the MA HIway PA as an addendum. PVIX will then accept the certificate from the HIway and the customers will be loaded into the HIway directory.

(Slide 35) Challenges we've Faced- Many of the EHR vendors are not ready with the necessary information exchange features and functions; PVIX is ready, but the trading partner is not. The legal review, like getting the PA vetted, was a long expensive process and it is best to get lawyers to the table early. This is a private HIE and we need to look at what value added services might look like in order to sustain ourselves.

(Slide 36) Future- Baystate wants this to be successful, and recognizes the need to make sure there is a good pricing model in place. At the end of the day, this is not about Baystate; it is about the entire patient population in Western MA.

Beth Israel Deaconess Medical Center (BIDMC) Mass HIway Progress Report, John Halamka, CIO BIDMC (slides 38-39).

(Slide 39) Progress Report – Quick update from Beth Israel Deaconess. Recognizing meaningful use stage 2 requires a variety of transactions to be sent including summary of care transactions, some aspects of quality reporting inside or outside EHRs, and three hospital based data transfers for immunizations reportable labs and syndromic surveillance – we have been focused on getting all of these going through the HIway. We've got 4,000-5,000 summaries a day going through the HIway to the MAeHC Quality Data Center. BID does not want the headache of dealing with the Quality Reporting Document Architecture (QRDA) quality computations and data submission requirements and have handed the headache over to Micky Tripathi and the Quality Data Center at MAeHC. As you think about innovation economy, this is the kind of thing the HIway allows us to do.

BID has figured out all of the consent questions for immunization submissions to the Department of Health (DPH) and transactions are now flowing for every immunization given at any site of care, inpatient or outpatient.

BID just went live with lab reporting. DPH is such an innovator that they were already live with lab reporting before Meaningful Use and are using a more advanced specification for lab reporting than the Meaningful Use certification requires. There are vendor readiness issues - chances are that Epic will be using a different spec than MA DPH and there needs to be reconciliation on the front or back end.

Summary of care documents are very important - payer provider, disease management, care coordination activities are important - so we are sending summary of care and lab data to Network health for use in disease management programs.

BIDMC is testing with DPH for syndromic surveillance. Boston Public Health is moving from The New England Healthcare Exchange Network (NEHEN) to the Mass HIway for labs and syndromic surveillance. BID can now send data across Longwood Avenue to Partners, recognizing that 27% of the patients have medical record numbers at BID and Partners.

Atrius is already receiving Continuity of Care Documents (CCD) information, but moving from NEHEN to the HIway. Both Atrius and BID would like the HIway to be the sole channel for information exchange. The biggest issue will be waiting for Epic functionality to enable the EHR to actually receive the information sent via the HIway. Meaningful Use Stage 2 EHR functionality requires the capacity to not only send, but receive and incorporate the CCD as structured data in the EHR. The issues of vendor readiness mentioned today get solved by meaningful use stage 2 because vendors must be able to work with the HIway using the Direct protocol for CCD generation, ingestion, and incorporation. We should see a lot of acceleration with Meaningful Use stage 2.

- Question (Laurance Stuntz): For Stage 2, will the Mass HIway need to be certified?
    - Answer (John Halamka): When ONC and HHS/CMS crafted the certification rules, they decoupled some important things and at the time there was a vision of cloud based quality reporting. They allowed for different standards to be used whether you had EHR functionality or modular functionality. The way they wrote the certification rule actually prohibits modularity in a very odd way - in that what you you are actually certifying the EHR's capacity to receive and submit transactions using the Direct protocol. To date they have not allowed a single script to be divided in half for modular certification. There are discussions underway to reconcile this as well as a workaround.

Discussion Item 2: Advisory Group Discussion & Updates presented by the Massachusetts eHealth Collaborative CEO Micky Tripathi (slides 30-39)

See slides 41-42 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides

(Slide 41) Advisory Group Update- There is a Technical Advisory Group meeting coming up in August to vet the Mass HIway phase 2 design - the design team is looking to get as much feedback as possible. The Legal & Policy and Provider Advisory Groups went deeper into consent and started to walk through policy and technical controls.

(Slide 42) Consumer AG Concerns- The Consumer Advisory Group raised the following two key issues: There is no formal consumer representation on the HIT Council. There is a need to formalize a consumer outreach campaign.

- Comment (Alec Ziss): One of the things the Consumer Advisory Group talked about was the need for consistency of content, but we are not exactly there yet in terms of what the content needs to be.
    - Response (Micky Tripathi): As much as we want to have the campaign, until the Phase 2 design is vetted we may not know the "ins and out" and should avoid being caught off guard.
- Comment (Manu Tandon): Manu noted that he was able to talk to Secretary John Polanowicz before this meeting and that the Council had asked for an HIT Council consumer representative in the January report. The Council will work to amend Chapter 224 and in the interim, accept nominations, but not as an official member until the law is passed. On the second point, EOHHS will take accountability for consumer outreach.
- Comment (John Halamka): John brought up the former Markle Foundation advertisement with the patient falling off the ladder and the message "You have two seconds to remember your entire medical history" and how a similar campaign could help the Mass HIway.
- Comment (Kathleen Donaher): Some research internationally shows that one of the problems with that public marketing approach is that for every positive message the public hears, there are two counterproductive messages. There is data out of Australia that shows this approach did not hit the individuals it needed to hit. We should take more of a community marketing approach.
- Comment (Alec Ziss): There are 6.6 million MA residents with varying degrees of understanding of medical records, their health and their relationships with their Primary Care Provider (PCP). There are also ethnic differences and religions differences which should be addressed by tailoring the message to different groups. The basic issue is, there needs to be a way to address the various groups. Getting marketing people involved may not work; will they be able to come up with a solution for each community? We need to tailor the presentations to so many different groups with different issues.
- Comment (Kathleen Donaher): It will inform our performance metrics.

Implementation and Support Update, Phase 2 Update, Manu Tandon (slides 43-47)

(Slide 44) Implementation- Currently there are 4 live sites exchanging data in production: Beth Israel Deaconess, MAeHC, Network Health and Tufts Medical Center. Boston Public Health Commission is ready for production.

(Slide 45) On the Bubble- Several organizations have successfully sent test messages and are close to live production. Those organizations include: Children's Hospital, Partners, Vanguard/Metrowest Medical Center and Pediatric Care Associates. Major clients slated for testing in August and September include Meditech, PVIX and Atrius. The Meditech platform pilot is already underway.

(Slide 46) Support- As Sean mentioned earlier, there is a big effort we need to get through as far as all of the Health Information Service Providers (HISPs) are concerned. There are ongoing discussions with Epic, eCW, eLINC, Surescripts and Athena (EHR systems). There is generic work that needs to happen at each

one of the HISPs, but when we make a connection once, it builds knowledge mushrooms for other providers to use.

(Slide 47) Phase 2 Overall Timeline- Since we last met the Phase 2 requirements gathering and validation has been completed. We want to capture all of the input from the community on that.

By in large the good news is that we are looking like we are going to have a solution that is going to be compliant with the direction set in February; essentially a way to use the HIE to lookup where the patients record sits, and to pull that information. It looks like the technology will be able to support the plan. There are several aspects still to be worked out, but everything so far is looking positive.

The Opiod Treatment Program (OTC) will join the HIway in September. There has been a significant amount of community stakeholder involvement which has been tremendously helpful. Thank you to everyone involved, and to Orion who has been a great partner.

There are 4 Council meetings left this year. The next meeting is September 9 on the 21st floor. Please refer to the information posted on the website. The preliminary agenda for the next meeting was reviewed.

The HIT Council meeting was adjourned at 4:49pm.